

Diagnosis and Management of Accessory and Cavitated Uterine Mass: A Case Report

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How to Cite this Article (Vancouver Style)

Das T, Biswas S, Sengupta T. Diagnosis and Management of Accessory and Cavitated Uterine Mass: A Case Report. Med J Ins Sc Tech. 2026;1(1):43–45. DOI: <https://doi.org/10.68003/mjiosat.v1i2>.

Abstract

Introduction: Accessory and cavitated uterine mass (ACUM) is a rare, new and underdiagnosed variety of mullerian anomaly possibly related to dysfunction of Gubernaculum, seen mostly in young, nulliparous women, with severe dysmenorrhea and pelvic pain.

Case Summary: A 23 year nulligravida presented with symptoms of severe dysmenorrhea and pelvic pain for a duration of 4 years, previously misdiagnosed with degenerated fibroid and cavitated rudimentary horn underwent Laparoscopic excision of the mass. Gross and histopathological examination revealed it to be ACUM.

Conclusion: ACUM is a commonly misdiagnosed entity. Both clinicians and radiologists need to be aware of it and have a high degree of clinical suspicion for diagnosis.

Keywords: Accessory and Cavitated Uterine Mass, Dysmenorrhoea, Laparoscopy, Mullerian anomaly

Article identifiers

eISSN: 3149-7497

Article ID: MJIOSAT-v1i1.a01

Pages: 44-47

DOI: 10.68003/mjiosat.v1i2



Scan to Access

Article History

Received: October 15, 2025

Revised: January 2, 2026

Acceptance: January 30, 2026

Published: April 30, 2026

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Introduction

ACUM is a new variety of mullerian anomaly that is generally located at the level of insertion of the round ligament and is possibly related to dysfunction of gubernaculum.¹ It has been kept under the unclassified division in the European Society of Human Reproduction and Embryology and Revised American Society of Reproductive Medicine classification of mullerian anomalies.

It was first described by J. Oliver in 1912 who on laparotomy found an accessory uterus distended with menstrual fluid in a 34 year old woman.² Since then, there had been no reported cases until in 1996 Tamura et al. described a 16 year old girl with juvenile adenomyotic cyst of uterus manifested as a cystic lesion independent of the uterine lumen.³ It was only in 2010 when P. Acien in his review article described ACUM and differentiated it from juvenile cystic adenomyosis (JCA).¹ ACUM, is most frequently seen in nulliparous women (<30 years) presenting with severe

dysmenorrhea and pelvic pain.

The criteria to diagnose ACUM given by P. Acien et al are: isolated cyst-like mass; normal uterine cavity, tubes and ovaries; exeresis of the mass with a pathology assessment; accessory cavity bordered by endometrial epithelium with glands and stroma; chocolate-brown-colored liquid content; and no adenomyosis.⁴

Here, we present a case of 23 year old unmarried nulliparous women with severe dysmenorrhea and pelvic pain who was misdiagnosed as degenerated fibroid and bicornuate uterus with cavitated rudimentary horn. Laparoscopic excision of the mass was done in the patient which revealed a cavitated mass not communicating with the uterine cavity containing chocolate colored fluid.

Case Presentation

A 23 year old Unmarried, Nulligravida with no sexual history presented with progressively increasing severe

dysmenorrhea and lower abdominal pain for 3 years.

The patient repeatedly sought treatment for her condition since 3 years, her symptoms improved initially with NSAIDs and a 6 month treatment with oral mifepristone. After stopping Mifepristone, her symptoms recurred and she started having excruciating lower abdominal pain not improving with medications, hampering her day to day activities. At another clinic, her transabdominal ultrasound showed bicornuate uterus with atretic right horn with differential diagnosis of myoma. Her MRI pelvis reported subserosal fibroid or an endometrioma. She underwent diagnostic laparoscopy at another centre where they diagnosed her condition as intramural myoma, with normal tubes and ovaries. No excision was performed for the same.

She presented to us with persistent symptoms of severe lower abdominal pain despite use of NSAIDs. On Examination, tenderness was elicited in the hypogastrium. A repeat transabdominal Sonography showed a thick walled mass protruding from right lateral uterine wall suggesting either ACUM or degenerated fibroid/adenomyoma. A hystero-Laparoscopy was planned for her. Prior to her OT, a bimanual examination was done under general anesthesia where a mass could be palpated in the right fornix.

Hysteroscopy examination showed a normal uterine cavity with two ostia. On laparoscopy, a mass measuring about 2*2 cm was visualised on the right anterior wall adjacent to the attachment of round ligament as seen in Image 1. Tumorectomy was performed and the mass was removed followed by repair of the myometrium. On cut section, the nodule spilled a retained dark brown colored substance. The inner lining of the mass on gross examination was smooth with surrounding muscular layer. Histopathology examination of the nodule confirmed the diagnosis of ACUM with features of adenomyosis in surrounding myometrium.

The post-operative course was normal and the patient was discharged from hospital on second post-operative day. The patient is currently asymptomatic.



Image 1: Laparoscopic view showing Location of ACUM

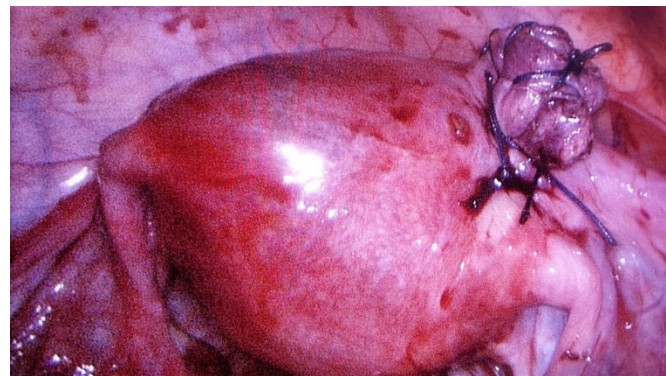


Image 2: Post resection and repair of ACUM



Image 3: Cut section shows smooth inner lining

Of cavity and surrounding muscle layer with brown Fluid oozing from the cavity

Discussion

Although, cases similar to ACUM were reported in literature, it was only in 2010 when Acien et al. described it as a separate clinical entity.¹ Stefan timmerman et al. in Feb 2024, reviewed 53 articles and reported 115 cases meeting with minimal criteria for ACUM.⁵ They concluded that a clear definition, investigation and management strategies need to be studied. Also, long term follow up of symptoms post treatment, fertility and pregnancy outcomes are required.⁵

Accessory cavity uterine masses are rare and may mimic other uterine conditions, making their diagnosis and management challenging. This case highlights several important aspects such as the need for a combination of imaging modalities (ultrasound and MRI), biopsy was crucial in differentiating this mass from other uterine pathologies. It underscores the importance of a multimodal approach in the evaluation of complex uterine masses and the diagnostic complexity involved with it. Laparoscopic resection proved effective for both diagnosis and treatment. This approach is advantageous in cases where the mass and associated cavity are well-defined.

Regular follow-up is essential to detect any residual or recurrent mass and to ensure resolution of symptoms. Long-term follow-up may be necessary depending on the patient's response to treatment and any future reproductive plans.

ACUM is less rare than believed but is mostly misdiagnosed. Clinicians and radiologists need to be aware of the entity and have high degree of suspicion for diagnosing ACUM. Prompt diagnosis is the key for early treatment. Clinical manifestation and imaging are mostly misleading and may incorrectly suggest other müllerian anomalies. Conventional ultrasound might not identify specific sorts of müllerian duct anomalies. MRI has been considered to be the optimal imaging method to identify endometriosis and müllerian malformations. The gold standard diagnostic modality being hystero-laparoscopy. For management,

surgical excision is both diagnostic as well as therapeutic approach for ACUM. ACUM was shown to be associated with endometriosis (10.0%), adenomyosis (5.7%), and infertility (4.3%).⁶ More Studies are needed to gain insight for conservative approach in management and its impact on future pregnancy.

Conclusion

This case report demonstrates the diagnostic and therapeutic challenges associated with accessory cavity uterine masses. The multidisciplinary approach involving imaging, biopsy, and surgical intervention provided a comprehensive strategy for managing this rare condition. Successful management of such cases requires careful evaluation and individualized treatment plans to address both the immediate symptoms and long-term outcomes for patients.

Integrity and compliance statements

Ethics approval

It's a simple case report so no ethical approvals take

Informed consent

This study used secondary data and it was not applicable

Funding

The authors did not receive any specific funding for this research.

Conflict of interest

The authors declare no conflicts of interest.

Data availability

No datasets were generated or analyzed for this study.

Provenance and Peer Review

Not commissioned; externally peer reviewed. Double-blind peer review.

AI/LLM disclosure

No AI-assisted tools were used in this manuscript.

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Acknowledgements

The authors would like to thank all the study participants of the study.

Author Contributions (CRediT)

Tanya Das: Corresponding author, conceptualization, validation, writing-original draft, reviewing and editing.

Sanjay Biswas: Supervision, writing- reviewing and editing, validation.

Trina Sengupta: Visualization, resources and literature review, reviewing and editing

Bios

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